

Clearance Form: Permission to Receive Massage Therapy, Integrative Cupping Therapy and Kinesiology Taping

I, _____, give permission for my patient,
(Print Name of PCP)

_____, to receive circulatory, therapeutic massage from
(Print Name of Patient)

a Licensed Massage Therapist from KK's Massage.

I understand that muscular therapy may bring about increased circulation of blood and lymph.

Integrative Cupping Therapy uses suction cups that would be applied to and moved on the skin to help with muscle tension, which can cause ecchymosis. Cupping massage and Taping is a highly circulatory modality that will cause vasodilation and increase vascular and lymphatic circulation. Cupping massage does activate the immune system. Please note below any cautions regarding medications as cupping massage can impact metabolism and absorption.

I also have reviewed this patient's medical records and have found no conditions or treatments that would contraindicate or caution hands on massage therapy. If I suggest any cautions or restrictions on massage, I have described them below:

(Date)

(Signature of Primary Care Provider)